Medicaid Information Bulletin

July 2005

Web address: http://health.utah.gov/medicaid

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BULLETINS BY TYPE OF SERVICE

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05 - 77 Utah Medicaid Prescriber Identifier (NPI)

The State of Utah Medicaid has entered into an agreement with The National Council for Prescription Drug Programs (NCPDP) to use the Council's prescriber database services.

HCIdea® is the National Council for Prescription Drug Programs (NCPDP) initiative to provide prescriber database services to those in the healthcare industry that need to identify all individuals who prescribe drugs. The applications for which the HCIdea database is ideal are numerous and include claims processing, electronic prescribing, prescriber utilization review, prescriber compliance auditing and provider database maintenance and cleansing activities.

Utah Medicaid and NCPDP have created a highly accurate Utah Medicaid prescriber file through a rigorous process of source data collection, normalization, standardization, validation and prescriber enumeration. The file contains records from the database that uniquely identifies each individual prescriber with an HCId® as well as information on practice addresses, DEA numbers, demographic information and other identifiers. The database services include a process to add new providers to the file and pharmacies to obtain routine updates of the file.

To correctly identify the prescriber, Utah Medicaid is asking all pharmacy providers to use the HCIdea identifier when sending a claim. The list/file is available free of charge to Utah Medicaid Providers. To activate your account and download your list/file, please contact Rita Rist at 800-269-8086, ext. 4216. Ms. Rist will provide you with the information necessary to access the Utah file at www.hcidea.org/utahfile.

Medicaid will still accept Medicaid Provider numbers, Medicaid-assigned license numbers, valid DEA numbers or a prescriber's last name (15 characters, no special characters or spaces) in the prescriber identifier field (filed 411-DB). Response code '56' (Non-match prescriber ID) will be returned if Utah Medicaid could not validate the prescriber identifier.

The prescriber ID qualifiers (field 466-EZ) that correspond with the prescriber identifier values are:
'05' Medicaid Provider number
'12' DEA number
'13' Medicaid assigned license number
'99' HCIdea identifier

If the prescriber ID qualifier is not valid, 'EZ' (M/I Prescriber ID Qualifier) will be returned. Response codes '56' and 'EZ' will not cause the claim to be denied.

New editing will be implemented effective August 1, 2005 and the following types of values in the prescriber identifier will be denied:

1. UT, Utah (upper or lowercase), MD
2. Repeated numbers or letters (example: 99999, 222XXX)
3. Single, double, or triple digits, letters or characters (example: A, 77, or DDD)
4. Anything beginning XX
5. Special characters (* / \ # $ % ^ & **, ; .? - ! + =, etc)
6. Spaces, leading or embedded
7. Four numeric digits
8. Anything beginning 123
9. DEA numbers begin with "A," "B," or "M". Anything beginning with any other letter followed by numbers is invalid. Two letters (space) and then seven numbers is invalid (example "AB 2541022").

For information from NCPCP about the HCIdea® please visit www.hcidea.org or contact Robin Ebert at 480-477-1000 ext.118 or rebert@HCIdea.org.

For a report of the invalid prescriber identifiers you are currently sending or if you need more information on valid identifiers, contact Kylene Hilton (801-538-9211) or Brenda Strain (801-538-6727) with the Bureau of Coverage and Reimbursement Policy. ☐

05 - 78 National Provider Identifier (NPI)

The National Provider Identifier (NPI) is the result of the mandate in the 1996 Health Insurance Portability and Accountability ACT (HIPAA) that the Secretary of HHS establish a standard national provider identifier. This new identifier, the NPI will replace many existing national (e.g., UPIN), state (Medicaid), and proprietary (individual hospital, healthcare system, commercial payer) provider identifiers. Though all healthcare providers will be eligible to receive NPI's, covered healthcare entities will be mandated to use the NPI as the sole provider identifier on all HIPAA electronic transactions. The 10 digit number will be assigned by a CMS funded NPI "Enumerator" through the NPPES (National Provider and Plan Enumeration System). The NPI Enumerator Contractor is FOX Systems, Inc. You may apply through an easy web-based application process, beginning May 23, 2005. The web address is https://nppes.cms.hhs.gov . A copy of a paper application, including the Enumerator's mailing address is also available on this web site.

Healthcare providers will be able to apply for NPI's starting on May 23, 2005, however the NPI will not be mandated as the sole identifier to be used in standard transactions with most health plans until May 2007 (May 2008 for small health plans). While the NPI must be used on standard transactions with health plans no later than May 23, 2007, health care providers should not begin using the NPI in standard transactions on or before the compliance dates. Medicaid will notify providers when to begin using NPIs in standard transactions to Medicaid.

When you receive your NPI number, please fax or mail the information to Medicaid Provider Enrollment, include your name and Medicaid Provider ID number.

Medicaid will keep you informed of our progress with implementing the NPI. ☐

05 - 79 Electronic Claims

Utah Medicaid is HIPAA compliant for all nine transactions. An EDI enrollment must be completed before providers can submit or receive the HIPAA compliant transactions. The form is available at http://health.utah.gov/hipaa/enroll.htm . Utah Medicaid Companion Guides are available at http://health.utah.gov/hipaa/guides.htm for each transaction.

If an attachment is required for your claim, do not drop to paper. Utilize the attachment control number on your electronic claim. The attachment must contain the same attachment control number and Medicaid provider ID as submitted on the claim. Attachments can be FAXed or mailed to Medicaid.

Medicaid has two trading partner numbers for claims submission. Claims submitted to the wrong trading partner number may be processed incorrectly.

Fee for service claims - HT000004-001
Crossover claims - HT000004-005

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05 - 80 Ambulatory Surgical Centers

Effective 10/1/05, Medicaid will be following the Utah Insurance Commission guidelines of utilizing the electronic 837 Institutional format (UB92) for claims submission. The companion guide is available at http://health.utah.gov/hipaa/guides.htm . ☐

05 - 81 Medicare/Medicaid Crossover Claim Submission

If a claim does not cross over from Medicare, providers can bill directly to Crossovers. Medicaid prefers the usage of the electronic claim submission. Complete the other payer payment information, including payer paid amount, patient liability and reason codes.

Submit to: HT000004-005 Utah Medicaid Crossovers.

Medicare Numbers Need to be on File

Providers wanting their Medicare claims to cross over to Medicaid need to have their Medicare Provider number on file with Medicaid. Physician Assistants and Nurse Practitioners need their Medicare number linked to the Supervising Provider's Medicaid number. Please contact Provider Enrollment at (801) 538-6155 or (800)662-9651 option 3, option 4 to update your provider record. ☐

05 - 82 Home Health Agencies: San Juan and Grand Counties Exception

To assure continued access to home health services for residents of San Juan county and Grand county, enhancements in home health reimbursement rates are provided. Effective January 1, 2005, for services provided in San Juan County and Grand County, the home health fee schedule is multiplied by 2.51 and 1.77 respectively to calculate the payment rate for applicable service codes. These enhancement factors are applied irrespective of the distances traveled to provide these services and are in lieu of the rural area exceptions provided for other rural counties. ☐

05 - 83 Dental

Beginning July 1, 2005, adult dental services will be restored to those with Traditional Medicaid coverage. This will include exams, preventive services, x-rays, fillings, extractions (including impactions), root canals (excluding 2nd and 3rd molars), partial dentures, dentures. This effectively restores the adult dental program to the same scope of coverage as prior to June 2002 when the program was cut.

Adults with Non-Traditional Medicaid coverage will continue to have only emergency dental coverage. Medicaid is waiting for federal approval of an 1115 waiver before that program can be expanded. You will be notified when the adult non-traditional dental program is expanded to the more limited PCN scope of dental coverage which may take several months.

Prior authorization requirements for D9220, deep sedation/general anesthesia are discontinued as of July 1, 2005. The criteria for use of this code remains the same and can be found in the Medicaid Dental Provider Manual. ☐

05 - 84 Speech

The limitation to one time service on code 92508, Treatment of speech, language disorder has been removed, but this code continues to require written prior authorization. ☐

05 - 85 Vision

Beginning July 1, 2005, adult clients with Traditional Medicaid coverage will receive an eyeglass benefit. This means that all Traditional Medicaid clients have the same vision care benefits.

SUMMARY OF VISION CARE BENEFITS

Benefit	Traditional Medicaid Plan (Purple Card)
Vision exams	Eye exams to determine refractions* are covered for all Traditional Medicaid clients (children and adults).
Eyeglasses	Eyeglasses (lenses and frames) are covered for all Traditional Medicaid clients (children and adults).
Care for medical problems of the eye	Eye exams and eye care to identify and treat medical problems (such as diabetic retinopathy, glaucoma, cataracts, etc.) are covered for all Traditional Medicaid clients (children and adults).

*prescription for glasses

Those with Non-Traditional Medicaid coverage do not have a benefit for eyeglasses. However, they will continue to receive one eye examination/refraction per calendar year for eyeglasses up to $30.00. In addition, eye exams and eye care to identify and treat medical problems of the eye (such as diabetic retinopathy, glaucoma, cataracts, etc) are covered for all Non-Traditional Medicaid Enrollees. Refer to Medical Information Bulletin April 2005, article 05-75. ☐

05 - 86 Transportation: Hospital to Hospital Transfers

If a Medicaid client, who is assigned to a Medicaid Health Plan, such as IHC, Molina, or HealthyU, is transported to a non-plan hospital emergency room the emergency transportation is covered by Medicaid. The additional transportation between the non-plan hospital and the plan hospital to facilitate coverage under the Health Plan is also covered by Medicaid and is not the responsibility of the Health Plans. ☐

05 - 87 Medical Supplies

S8121, Oxygen contents, Liquid is open for use with liquid oxygen rental systems E0439 after the first ten pounds which are included in the rental of the delivery equipment each month. One unit = one pound and currently pays $0.80 per unit.

The manual correction: Code E0443, oxygen contents, one unit = 50 cu ft and not 5 cu ft as formerly listed. The pricing has been changed to reflect this correction. Oxygen will continue to be paid at $0.09 per cubic foot. This will change the pricing from $1.75 to $4.50 per unit for this code.

Gastronomy tubing and buttons are covered under code B9998. This code is only open for gastronomy tubing and buttons. Annual limitations are four buttons and four sets of tubing. When billing this code please give additional information to identify the units for buttons and units for tubing to enable the Medicaid staff to manually price these items.

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05 - 88 Physician Services: Corrections/Clarifications

Y codes

Some of the Y codes were inadvertently left in the physician manual and are now corrected as follows:
Under covered service 32. Maternity Care

B. Labor and Delivery

2. **Woman with an Emergency Services Only Card**

Only labor and delivery codes are billable for a woman with an Emergency Services Only card.

- High risk vaginal delivery code 59409–22
- High risk cesarean delivery code 59514–22

E. High Risk Pregnancy

– Codes

code H1000 Low risk assessment (limited to two)
code H1001 High risk Assessment
code 59400–22 High risk vaginal delivery (global)
code 59510–22 High risk cesarean delivery (global)
code 59409–22 High risk vaginal delivery only
code 59514–22 High risk cesarean delivery only
code 59410–22 High risk vaginal delivery with postpartum care
code 59515–22 High risk cesarean delivery with postpartum care

Pain Management

The code 01997 used for daily pain management for patients with patient controlled anesthesia (PCA) is a discontinued code. The modifier 22 cannot be used with evaluation and management services. In order to be HIPPA compliant, the code 01997 and modifier 22 will be removed from the Anesthesia Manual describing initial pain management coding for PCA.

The anesthesiologist may bill the subsequent hospital code at the appropriate level of service with the 24 modifier on the date of surgery for the initial set up of PCA. The subsequent hospital care code at the appropriate level of service may be billed daily as long as medical record documentation supports daily management of the PCA. Review of submitted claims indicates, the code 99231 is the most frequent service billed on subsequent days for PCA daily pain management.

The pain management policy will be edited to allow the following services for an episode of care.

1. Epidural or Nerve Block as a Continuous Infusion (following code 62318 and 62319 on the list)

*64416 Injection, anesthetic agent, brachial plexus, continuous infusion by catheter
*64446 Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter
*64448 Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter

*Select one of these codes for neuraxial narcotic injections or placements of catheter that are not used as part of the general anesthetic and are used solely for the purpose of post operative pain management. Payment should not be denied as part of another service or a global fee.

01996 Daily follow-up and management of the continuous catheter infusion. Units will be attached to the code but no time (A “0" is not an appropriate unit to use in this field.) Payment will be made once daily beginning the day after the surgical procedure.

2. Epidural or Nerve block as a Single Injection

*62310 Injection, single (not via indwelling catheter) not including neurolytic substances, with or without contrast, epidural or subarachnoid; cervical or thoracic
*62311 Injection, single (not via indwelling catheter) not including neurolytic substances, with or without contrast, epidural or subarachnoid, lumbar, sacral (caudal)
*64415 Injection, anesthetic agent, brachial plexus, single
*64417 Injection, anesthetic agent; axillary nerve, single
*64445 Injection, anesthetic agent; sciatic nerve, single

*64447 Injection, anesthetic agent; femoral nerve, single
*64450 Injection, anesthetic agent; other peripheral nerve or branch

*Select one of these codes for a single epidural or nerve block whose primary purpose is for postoperative pain, and unrelated to anesthesia for surgery. Payment will only be made once during an episode of care. Payment should not be denied as part of another service.

3. Patient Controlled Analgesia (P.A.)

*99231-24 Subsequent Hospital Care
*99232-24 Subsequent Hospital Care

*Select one of these codes for the initial set-up and placement of the PCA. Payment should not be denied as part of another service.

For subsequent daily pain management on the days following the initiation of PCA, use the subsequent care code 99231 with modifier 24. The subsequent hospital care 99231 code will replace code 01997 for daily pain management of the PCA.

Neurological Monitoring During Anesthesia

The CPT manual descriptor for code 95955, electroencephalogram (EEG) during non intra cranial surgery, may be used for BSI. Bispectral index monitoring (BSI) is used by anesthesia to monitor the level of anesthesia which will reduce the risk of patient awareness. The codes 95812 and 95822 may also be used to provide EEG monitoring. Routine monitoring, including EEG monitoring is included within the primary anesthesia and not reimbursed separately.

Neurological monitoring is considered included within neuroanesthesia procedures. Code 95925, 95926, 95927, 95928, 95929, 95930, and 95937 will produce an incidental denial in the editing program with anesthesia services that may warrant this type of monitoring.

Anesthesia code 01964

Anesthesia for abortion, code 01964, will require manual review. There is not a separate code for missed abortion. In order to comply with legal requirements we must insure providers are not reimbursed by Medicaid for unauthorized procedures. The diagnosis code 632–missed abortion, will be accepted with the procedure code 01964. All other diagnoses will require manual review of documentation for payment.

Pulse Oximetry

The editing program will deny code 94761 (in addition to code 94760) as incidental to the Evaluation and Management service.

Chiropractic Service

For code 98940 through 98943, the note on CPT list of Medical Surgical Procedures related to Y codes no longer applies. All chiropractic services are contracted services through Chiropractic Health Plan and require pre-authorization through the plan. The note was replaced on the CPT list to reflect this information.

Manual Therapy Techniques

According to the CPT manual definition, the code 97140 is used to describe manual therapy techniques which may be required in patients with restricted joint motion or lymphedema. The goal of the therapy is decrease lymphedema by opening up functional pathways and preventing back flow as the new pathways become established. The therapy involves extensive treatment to decrease the size of an extremity by a combination of manual decongestive therapy and serial compression bandaging followed by an exercise program. Education of the patient is expected so that after a short course of therapy the patient and/or care giver can preform activities to maintain the patient. When used in patients with restricted joint motion, the therapy is used with therapeutic exercise to improve intra articular motion and flexibility.
The service is open to the osteopath, physician and group practice. The **code 97140 cannot be used to bill for Rolfing**, a non-covered service in Medicaid. Rolfing is an alternative medicine therapy which is considered investigational and unproven.

Allergen Immunotherapy

There is some confusion related to the correct billing of code 95165. This issue was recently brought to light when Medicare issued an alert about a non-covered service called EDI therapy. Because this therapy is considered investigational, the therapy is not covered by Medicaid or Medicare.

Code 95165 represents preparation of vials of non-venom antigens. This service includes the physician's evaluation of the antigens required to treat the allergy, antigen concentration, and the volume required for the planned schedule of injections based on skin testing and patient history. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in separate vials. For example, mold antigens are prepared in a vial and pollen antigens are prepared in a separate vial. Therefore, some patients will be injected at one time from one vial - containing one mixture of the appropriate antigens while other patients will be injected at one time from more than one vial. The most common vial size is 10 cc. The code 95165 is based on the number of prepared doses in a vial (10). The dose provided to the patient may be less than one cc. If the prepared number of doses in the multi dose vial is less than 10 cc, the provider is advised to bill for that number of doses. However, if the planned number of doses was 10 and the provider ended up using only eight doses, ten doses are covered. Injections are billed separately. In the case of preparation of doses of pollen and doses of mold it is medically necessary to prepare the mold extract separately from the pollen extract. The provider may bill for more than one 10-cc multi dose vial. Requirements for more than 20 doses under code 95165 are rare. The code is normally billed once every twelve months. In rare circumstances the code has been billed nine months apart. Therefore, the program edits will deny payment for code 95165 when the number of doses (units) billed exceeds twenty over a nine-month period.

Operating Microscope

CPT guidelines indicate that the procedure code 69990 should not be reported when the microscope is used as a method of magnification only and micro surgical techniques are not being utilized. The editing program will deny code 69990 when submitted with procedures 69420-69436.

Emergency Room

In the hospital setting the radiologist prepares the official interpretation and report for imaging studies. Review of radiological examinations by the emergency room physician is considered part of the emergency room service provided in codes 99281-99285. Therefore, separate reimbursement is denied by the editing program.

Endoscopy

During audits three codes were discovered which did not have ranking on them. The editing program and consultant physicians agree the codes should be ranked. This correction will be made to the reference file for code 43231 (with endoscopic ultrasound examination), code 43232 (with trans endoscopic ultrasound-guided intramural or trans mural fine needle aspiration/biopsy(s)) and code 43242 (with trans endoscopic ultrasound-guided intramural or trans mural fine needle aspiration...).

Separate Procedures

A statement in the provider manual related to starred * procedures will be removed. Starred procedures were removed from the CPT manual in 2004. The CPT manual defines these as separate procedures. Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided, for example diagnostic examination prior to a therapeutic procedure. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure. " The "separate procedure" designation indicates that a certain procedure or service may be: a) Considered an integral component of another procedure/service, b) Performed independently, c) Unrelated or d) Distinct from other procedure(s)/service(s) provided at that time. Procedure codes designated as "separate procedures" may not be additionally reported when the procedure/service is performed as an integral component of another procedure/service.
However, procedure codes designated as "separate procedures" should be additionally reported when performed independently, as unrelated or distinct procedure from the other procedure(s)/service(s) provided. If the physician performs a designated "separate procedure" in addition to another procedure which is unrelated to the "separate procedure", modifier -59 should be appended. This modifier is used to indicate the designated "separate procedure" was unrelated or a distinct service from another procedure. Modifier 59 is subject to review of submitted medical record documentation for separate and distinct service.

Digital Mammography

Digital Mammography add-on code 76082 and code 76083 were placed in the CPT manual, January 2004. The CPT manual instructs the provider to submit the add-on code 76082 or 76803 with the code for standard mammography, code 76090 or 76091 or 76092 to indicate digital mammography was completed. The add-on codes 76082 and 76083 will be opened in the reference file for coding purposes to pay zero, beginning January 1, 2005. The provider may complete standard or digital mammography. However, Medicaid will continue to pay the reimbursement rate for standard mammography.

CPT codes Covered

77301 Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim. [1]

77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim. [1]

Sleep Studies in Children

Prior approval for a sleep study in children is required through Utilization Review committee. Documentation must be submitted to the prior authorization nurses supporting the medical necessity for the procedure. Required documentation must include:

Full history and physical
Relevant prior evaluation and management services completed
Pertinent imaging and laboratory reports
Previous consultations
Differential diagnosis with the working diagnosis (the reason for referral)

This information must be accompanied by a signed statement from the primary care provider or referring physician that they are willing to resume the care of the patient from the Sleep Specialist. If the provider prefers to have the Sleep Specialist work up the patient and provide some treatment, there must be agreement that either the referring physician will resume patient care or the name of the Medicaid physician who as agreed to take over the care from the Sleep Specialist.

Criterion #44 Intensity Modulated Radiation Therapy (IMRT) (Code 77301 and code 77418 only)

Indications and Requirements for Coverage

1. Currently IMRT is indicated for primary brain tumors, brain metastasises, prostate cancer, lung cancer with respiratory gating for motion, bladder cancer, pancreas cancer, and other upper abdominal sites with provision for organ motion, spinal cord tumors, head and neck cancer, adrenal tumors, pituitary tumors, and situations requiring extremely high precision in radiation treatment to reduce the incidence and severity of radiation side effects. An IMRT candidate may include a patient who has already received a maximum amount of radiation delivered by conventional means.

2. IMRT is considered reasonable and medically necessary in instances where sparing the surrounding normal tissue is essential and the patient meets at least one of the following conditions:
   a. Important dose limiting structures are adjacent to, but outside of the planned treatment volume area and IMRT is used to increase safety and reduce morbidity. The volume area can only be defined by MRI or CT.
   b. The immediately adjacent volume area has been irradiated and adjacent areas must be targeted with high precision.
   c. Gross tumor volume margins are concave, convex, or irregular and in close proximity to critical structures which must be protected. IMRT is the only option to cover the volume of interest with narrow margins and protect immediately adjacent structures.
   d. Non - IMRT techniques increase the risk of grade 2 or grade 3 radiation toxicity in greater than 15 percent of radiated cases.

3. Documentation in the patients medical record must include all of the following:
   a. Statements by the treating physician documenting the special need for preforming IMRT on the patient in question instead of conventional or 3-dimensional radiation treatment planning and delivery.
   b. The prescription for treatment must include the goals and requirements for treatment and documentation must include:

1. The specific doses needed in the planning of target volume and constraints with surrounding normal tissue;
2. Patient positioning and immobilization requirements;
3. The need for respiratory, cardiac or other organ protection if structures are moving in and out of high and low dose regions; and
4. The means of dose verification and secondary means of verification (With the first IMRT treatment plan, need for verification of dose and monitoring of generating units should be addressed).

Limitations

A. IMRT is not a replacement therapy for conventional and 3D conformal radiation therapy.

B. IMRT is not considered reasonable and necessary unless the diagnosis is malignant neoplasm and radiation treatment of extremely high precision is required. ☐

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05 - 89 Hospital Manual Clarification – Free Standing Ambulatory Surgery Centers

Lithotripsy is paid under a global fee to all providers including Free Standing Ambulatory Surgery Centers. This issue will be added to the limitations section in the Hospital Manual, item 21, Lithotripsy. "Payment for Lithotripsy is set at a global rate. The payment rate and conditions for coverage are the same regardless of the site of service." ☐

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05 - 90 Zelnorm Prior Authorization Criteria, Clarified

Zelnorm prior authorization Criteria has been clarified. Prior authorization criteria are as follows:

Written Prior for Six Months

1. The treatment of patients <65 years old with Chronic Constipation.
    a. Recommended dosage: 6mg bid with:
        a. Documented failure within the last 12 months using:
            1. One fiber laxative and twos stimulant laxative products.
        b. Rule out drug induced constipation. (i.e. narcotic pain meds)
2. Re-authorization after 6mo. Patient will need to show trial off Zelnorm using other laxatives for at least 45 days.

The reason for the Prior authorization is to rule out opiate induced constipation for which Zelnorm is not indicated and not appropriate. Management of constipation for reasons other than Irritable bowel syndrome and Chronic Idiopathic constipation should not default to the use of Zelnorm but rather other appropriate, less expensive interventions that have historically been used effectively without adverse events. According to FDA and manufacturer indications, Zelnorm has not been approved for use beyond 12 weeks. Nevertheless, prior authorizations will be for 6 months, during which time case management should focus on a transition to more traditional treatments. ☐

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05 - 91 Palladone on Prior Approval; Criteria

Prior approval status for Palladone (Hydromorphone SA) capsules was recommended December 9, 2004 by the Drug Utilization Review (DUR) Board with continuing discussion. Criteria were finalized at the March 2005 DUR Board meeting and are as follows:

1. Indicated for severe pain in opioid tolerant patients.
2. Must fail on three other long term opioids including methadone within the last 6 months. Failure on these three narcotics must be based on allergy or other adverse drug effects, not failure of efficacy.
3. Chronic non-malignant pain limited to 30 capsules per 30 days in any combination of strengths.
4. ICD.9 for cancer and a prior approval to have uncontested access to higher doses. ☐

05 - 92 Restasis on Prior Approval; Criteria

Prior approval status for Restasis (Cyclosporine 0.05%) ophthalmic drops was recommended January 13, 2005 by the DUR Board. The recommended criteria are as follows:

A. Approved for the following diagnoses (ICD.9):
370.20 superficial keratitis, unspecified
370.21 punctate keratitis
370.33 keratoconjunctivitis sicca, not specified as Sjogren=s
710.2 sicca syndrome - Sjogren=s disease

Diagnoses determined by fluorescein dye on the cornea with evaluation via the staining of the cornea with a slit lamp and cobalt blue light.

1. Correct ICD.9 code
2. Documented fluorescein test
3. Request from ophthalmologist or with documented ophthalmologist consult

B. Approved for post corneal transplant (ICD.9):

V42.5 post corneal transplant

1. Correct ICD.9 code

C. Approvals are for 1 year

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05 - 93 Macugen; MD Office Only- Billed via J-code; Criteria

The DUR Board voted to support the use of Macugen for the treatment of the wet form of Age-related Macular Degeneration through the physicians office billed with a j-code. This product is administered intravitreously which means that it will not be available through pharmacies but exclusively through the doctor's office. Since this would be used primarily for patients aged 65 years and older, Medicaid will only cover what Medicare does not cover. ☐

05 - 94 Outpatient No Longer Reporting ICD-9 Surgical Codes

Due to HIPAA regulations, Medicaid cannot require the ICD-9 surgical code for outpatient services. Medicaid will require the HCPCS code related to the surgery performed. The HCPCS code should be reported where the ICD-9 surgical codes were reported previously.

Electronic -
(Principal Procedure Information)
2300 HI01- Report BP
2300 HI01-2 - Report HCPCS code and date associated to surgery performed.
(Other Procedure Information)
2300 HI01 - Report BO
2300 HI01-2 through HI12-2 - Report HCPCS code and date associated to surgery performed.

Paper - Box 79 - Report 5
Box 80, 81 - Report HCPCS code(s) and date associated to surgery performed.

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05 - 95 Child Health Evaluation and Care Manual Updated

The Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services is updated as follows:

A revision to the recommended age for developmental screening, Section 2, Chapter 2- 2 Comprehensive History - age is changed to read “birth to 60 months”.

A revision to the recommended age for using social emotional screening tools , Section 2, Chapter 3- 4 Mental Health Services - age is changed to read “children birth to 60 months”.

The revised Chapter 2, Mental Health Services is on the Internet. Look for the link to the CHEC manual at: www.health.state.ut.us/medicaid/section2list.pdf.

In the updated manual, a page which states “Page Updated May 2005” on the upper right of the page has a new correction or clarification. If you do not have internet access, contact Medicaid Information for a copy of the revised CHEC manual, or use the Publication Request Form. ☐

05 - 96 Emergency Only Records Submission

Federal Regulations regarding the Emergency Only Program require the state to verify that the situation treated met the state and federal definitions of an emergency condition. Currently providers requesting payment under the Emergency Only Program submit the claim which is suspended for medical review of the records. Those records are sent in and evaluated. This causes significant delays in final resolution of the claim.

Effective immediately providers may submit the required documentation one of two ways.

1. You can drop the claim to paper and submit the records with the claim for processing. This will eliminate the need to wait until the claim has been processed initially, and then submitting the supporting documentation. This will result in more timely processing of the claim.

2. You can submit the claim electronically. Be sure and include the attachment control number on the claim. FAX or mail your documentation to Medicaid indicating the same attachment control number and Medicaid provider ID as submitted on the claim. Once documentation is received, the claim will be processed. If no documentation is received, the claim will be denied.

We anticipate retaining this process until there is a national process adopted that will allow electronic attachments to be submitted with the claim. At that time the process will be reevaluated to determine the most responsive and appropriate method of submitting the documentation. ☐